Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

[redacted] 07600

Reg. Diat. No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 131 Race Street.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 131 Race St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Luther Boyd Anderson

3.(b) Social Security Number 205-05-5577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Reva Moore

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1899

8. AGE:

Years	Months	Days	If less than one day
46	8	6	hrs. min.

9. Birthplace: Vinton Va.
(Town, county, and state)

10. Usual occupation: Boiler

11. Industry or business: R.R. Co.

FATHER 12. Name: Alfred M. Anderson

13. Birthplace: Va.

MOTHER 14. Maiden name: Belle Stiff

15. Birthplace: Va.

16. Informant: Mrs Reva Anderson

Address: Cumberland Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: Aug 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Vinton Cem

Location: Vinton Va

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Aug 12 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946 to August 11 1946 and that I last saw h[illegible] alive on August 11 1946

Immediate cause of death	DURATION
Chronic Myocarditis.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin M.D.
M. D. or other

Address: Cumberland, Md. Date signed: 8-12-46.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

07601

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: New Cumberland, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Mepris Farm R.F.D. #4 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Baker

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

8.(b) Name of husband or wife: Mary Elbin

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 30, 1859

8. AGE: Years: 87 Months: 6 Days: 5 If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Boatman

11. Industry or business: Retired

FATHER 12. Name: Leo Baker

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Christina Fauer

MOTHER 15. Birthplace: Germany

16. Informant: Joseph F Baker

Address: Casper Wyoming

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 7, 1946 (month) (day) (year)

Cemetery or crematory: St Peter & Paul

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Aug 7 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1946, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5. 4. 1946 to 8. 5. 1946 and that I last saw him alive on 8-3- 1946

	DURATION
Immediate cause of death: Cardiac arrest	
Due to: Left ear	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. F. Williams M. D. or other

Address: Cumberland Date signed: 8-5-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ 07602

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 12 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: (Route) Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. RFD #3, Valley Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lulu Berta Virginia Bartlett

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Millard F. Bartlett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 15 1869

8. AGE: Years	Months	Days	If less than one day
76	11	16	..... hrs. ..... min.

9. Birthplace: Buchanan W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER — 12. Name: James Cartwright

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Margaret J. Cartwright

15. Birthplace: W. Va.

16. Informant: Millard F. Bartlett

Address: RFD #3 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 46 (month) (day) (year)

Cemetery or crematory: Union Memorial Cem.

Location: Route Cumberland

18. Funeral director: Louis Stein & Son

Address: Cumberland

19. Aug 3 1946 (Date rec'd by registrar) Joseph A. Sullivan M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1, 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1946 to 8/1/46 19..

and that I last saw ~~him~~ alive on 8/6/46 19..

Immediate cause of death: Diabetes Mellitus — DURATION

Due to: — DURATION

Due to: — DURATION

Other conditions: — DURATION

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D Kesler M. D. or other

Address: 122 Bedford St Date signed 8/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07603

★ Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: called Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John L. Beal

3. (b) Social Security Number: 220-10-0952R

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Laura Beal

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Mar. 13 - 1876

8. AGE:

Years	Months	Days	If less than one day
76	5	14	..... hrs. ..... min.

9. Birthplace: Somerset Co. Pa.

(Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Brickyard

FATHER

12. Name: Simon Beal

13. Birthplace: Somerset Co. Pa.

MOTHER

14. Maiden name: Ella Neumann

15. Birthplace: md.

16. Informant: Mrs. Charles Lennet

Address: Mt. Savage, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug 29-1946 (month) (day) (year)

Cemetery or crematory: St George

Location: Mt Savage, Md.

18. Funeral director: J. J. Lentz

Address: Frostburg, Md.

19. 8-28 1946 (Date rec'd by registrar) Veronica McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1946 at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1946 to August 27 1946 and that I last saw him alive on August 27 1946

Immediate cause of death	DURATION
Carcinoma Stomach	6 months
Due to	
Due to	
Other conditions: Carcinoma Liver; Carcinoma Lymph Glands -	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William E. Moseley M. D. or other

Address: Mt Savage Md Date signed: 8-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

Within corporate limit Van Olmer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

07604

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 827 Buckingham Road (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Alonzo Herbert Bennett

3.(b) Social Security Number 705-01-9094

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife Anna "Cavanaugh" Bennett

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) January 2, 1885

8. AGE: Years 61 Months 7 Days 19 If less than one day ... hrs. ... min.

9. Birthplace Rochester, New York (Town, county, and state)

10. Usual occupation Supt. of Back Shops

11. Industry or business B&O RR

FATHER

12. Name Frank Bennett

13. Birthplace Rochester, N.Y.

MOTHER

14. Maiden name Nellie Blackman

15. Birthplace Rochester, N.Y.

16. Informant James J. Conner, Jr.

Address 827 Buckingham Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 23, 1946 (month) (day) (year)

Cemetery or crematory Morningside Cemetery

Location Du Bois, Pa.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Aug. 21, 1946. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1946, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 July 1946, to 21 Aug 1946

and that I last saw him alive on 20 Aug. 46 19

Immediate cause of death

1. Pneumonia, primary atypical rt. middle & lower lobe, probably virus type. — DURATION (about 6 wks.)

Due to

2. Encephalitis, acute, secondary to above. — 1 wk.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE W. A. Van Olmer M. D. or other

Address 110 S. Centre St. City — Date signed 21 Aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

Evidence for change of age of deceased is shown on

FILM No. I 06 SEP 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

07605

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany County Infirmerary
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Valley Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Angeline Amelia Bobo

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Lee Bobo
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1865

8. AGE: Years	Months	Days	If less than one day
81 ~~82~~	0	3	..... hrs. ..... min.

9. Birthplace: Moorefield, W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jonathon Halterman
13. Birthplace: Va.

MOTHER
14. Maiden name: Millie Caldwell
15. Birthplace: Va.

16. Informant: Mr. Robert Bobo
Address: R.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 19, 1946 (month) (day) (year)
Cemetery or crematory: Newhouse Cem.
Location: Near Moorefield, W. Va.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Aug 19 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16, 1946, at [illegible] M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-6 1946 to 8-16 1946 and that I last saw h[illegible] alive on 8-13 1946

	DURATION
Immediate cause of death: Pneumonia	3 days.
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Carbuncle on back	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. None
Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or Other
Address: Cumberland Date signed 8-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

★ 07606

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: National Frostburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: National (Frostburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hazel T. Atkinson Brodie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Andrew Brodie Jr.

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): July 31, 1904

8. AGE: Years: 42 Months: 0 Days: 25 If less than one day: hrs. min.

9. Birthplace: Gilmore, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: James Atkinson
13. Birthplace: Frostburg, Md

MOTHER
14. Maiden name: Clara Brown
15. Birthplace: Macon

16. Informant: Leslie Brode
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29 1946 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md.

19. 8-27 1946 (Date rec'd by registrar) Jaunteen Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1946 to Aug 26 1946

and that I last saw h[illegible] alive on Aug 26 1946

Immediate cause of death	DURATION
Ante Partum Hemorrhage	
Due to: Premature separation of placenta	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N.D. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed: Aug. 27 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07607 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs 12
Hospital, institution, or street address where death occurred: St. Mary's Terrace
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary Brown

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John L Brown
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): May 31, 1869
8. AGE: Years: 77 Months: 2 Days: 12 If less than one day: hrs. min.
9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: Own Home
FATHER 12. Name: Robert G Wilkie
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary Hardy
MOTHER 15. Birthplace: Scotland
16. Informant: Miss Mary Brown
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15 1946 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md
18. Funeral director: W. H. Eichhorn
Address: Lonaconing, Md
19. Aug 14 1946 (Date rec'd by registrar) Jeanette M Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 1946, at 7 15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1946, to Aug 13 1946 and that I last saw h.e alive on Aug 12 1946

Immediate cause of death	DURATION
Carcinoma of Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed: Aug 13 '46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

07608

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
632 Fairmont Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 632 Fairmont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William Martin Cessna

3.(b) Social Security Number
705-10-8539

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Minnie Knieriem Cessna

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 20, 1886

8. AGE:	Years	Months	Days	If less than one day
	60	4	19	hrs. min.

9. Birthplace: Cresaptown, Md.
(Town, county, and state)

10. Usual occupation: Passenger Brakeman

11. Industry or business: Western Md. Railway Co.

FATHER
12. Name: Wm. C. Cessna
13. Birthplace: Bedford Valley, Penna.

MOTHER
14. Maiden name: Annie Smith
15. Birthplace: Penna.

16. Informant: Mrs. Minnie Cessna

Address: 632 Fairmont Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1946 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Aug. 10, 19 46 (Date rec'd by registrar) H. C. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 9, 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 19 46, to Aug 8 19 46 and that I last saw h alive on Aug 8 19 46

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to Cancer of Kidney.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. H. Williams M. D. of other

Address Date signed 8/10/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3146)

07609

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? +0 yrs.

Hospital, institution, or street address where death occurred: 719 N. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 719 N Centre St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Christian

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 18 1866

8. AGE:

Years	Months	Days	If less than one day
79	7	29	..... hrs. ..... min.

9. Birthplace Va.

(Town, county, and state)

10. Usual occupation Laborer (Retired)

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Belle Taylor

Address 719 N Centre St. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 46 (month) (day) (year)

Cemetery or crematory Evergreen Cem.

Location Cumberland

18. Funeral director Lonig Stein Inc

Address Cumberland

19. Aug. 19, 1946 (Date rec'd by registrar) Jos. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946, at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1946, to Aug 17 1946

and that I last saw him alive on July 27 & 1946

	DURATION
Immediate cause of death (Chronic Nephritis + Congestive Heart Failure	10 yrs
Due to Infirmities of age.	
Due to Chronic alcoholism	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Thomas M. D. or other

Address Cumberland Md Date signed 8/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits ✓ F. W. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07610

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
114 N. Cedar St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County:

City or town: Fostoria
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Columbus Ave
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Mae "Rairigh" Coblentz

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Isaac Coblentz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 4, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	9	hrs. min.

9. Birthplace: Peabody, Kansas
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER
12. Name: James Q Rairigh
13. Birthplace: Ohio

MOTHER
14. Maiden name: Louise Dickey
15. Birthplace: Ohio

16. Informant: Mrs. Arthur Seroguem
Address: 114 N. Cedar St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 17, 1946 (month) (day) (year)

Cemetery or crematory: Metzger Cemetery

Location: Peru, Indiana

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Aug. 14, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1946, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from S. 13. 1944 to 8. 13. 1946 and that I last saw her alive on 8. 12. 1946

	DURATION
Immediate cause of death: Chronic Myocardial Degeneration	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

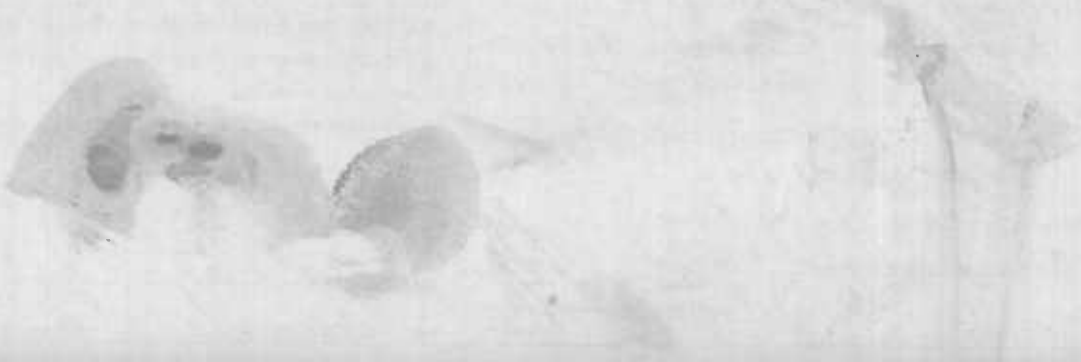
23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 8-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Underline the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07611

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 61 years
Hospital, institution, or street address where death occurred:
Algonquin Hotel
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Algonquin Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Dr Frank Garnett Cowherd

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Irene Utterback
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Mar 1, 1885

8. AGE: Years	Months	Days	If less than one day
61	5	2	hrs. min.

9. Birthplace: Cumberland, Alleg Co, Md. (Town, county, and State)
10. Usual occupation: Medical Doctor
11. Industry or business: Private Practice

FATHER
12. Name: Wm Cowherd
13. Birthplace: Orange Co. Va.

MOTHER
14. Maiden name: Lorella Conrad
15. Birthplace: Luray Va

16. Informant: Mrs. F. G. Cowherd
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 6 1946 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland Md

18. Funeral director: John J. Hafer
Address: Cumberland Md

19. Aug. 5 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1946, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 aug. 1946 to 3 aug. 1946
and that I last saw him alive on 3 aug 1946

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Coronary Heart Disease	7 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Alfred Van Ormer M. D. or other
Address: 110 S. Centre St Date signed: 5 aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

07612

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine S. Eisentrout

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 30, 1912

8. AGE: Years	Months	Days	If less than one day
33	9	25	hrs. min.

9. Birthplace (Town, county, and state): Eckhart Allegany Maryland
10. Usual occupation: housework
11. Industry or business: home
12. Name of father: John Eisentrout
13. Birthplace of father: Maryland
14. Maiden name of mother: Matilda Crawford
15. Birthplace of mother: Penna.
16. Informant: George Eisentrout
Address: Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 '46 (month) (day) (year)
Cemetery or crematory: St Michaels
Location: Frostburg Md.
18. Funeral director: J. P. Dupist
Address: Frostburg Md.
19. Aug 26 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1946, at P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1946, to August 24 1946
and that I last saw h[illegible] alive on August 24 1946
Immediate cause of death: diabetic coma — DURATION: 2 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L Bliss M.D. M. D. or other
Address: 59 Green St. Date signed: 8-26-46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

FILM No. I 06 AUG 23 1946

CERTIFICATE OF DEATH

07613

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Glendale St. Glendale St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kenneth Emmson

3.(b) Social Security Number: 219-03-8104

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ada L Maher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17 1872

8. AGE: Years	Months	Days	If less than one day
73 - 74	10	21	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: "

MOTHER — 15. Birthplace: "

16. Informant: Rosie M Otten

Address: Wiley Ford W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Sons

Address: Cumberland Md

19. Aug. 12 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1946, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to Aug. 8 1946 and that I last saw him alive on Aug. 8 1946

Immediate cause of death	DURATION
Anaemia	years 3
Myocarditis	months 6
Due to: Pernicious Anaemia	days
Due to:	hours
Other conditions:	minutes

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clark Sturm M.D. or other

Address: Cumberland Date signed: Aug. 8, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

(119a) 07614

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town WESTERNPORT
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME FAZENBAKER, BABY GIRL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 27, 1946

8. AGE: Years	Months	Days	If less than one day
	~~2~~	3	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER
12. Name FAZENBAKER, WILLIAM,
13. Birthplace MARYLAND

MOTHER
14. Maiden name WHITE, ADRIAN
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 Sept 46 (month) (day) (year)

Cemetery or crematory Maryhurst Cem.

Location Keyser, Md

18. Funeral director Ellsworth A Bond

Address 111 Church St. Westernport, Md

19. Aug 31 1946 (Date rec'd by registror) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 31, 1946 at 7:40A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 27 1946 to Aug 31 1946

and that I last saw h.e alive on Aug 31 1946

Immediate cause of death	DURATION
(a) Congenital Debility	2 hrs
Due to (b)	
Due to (c)	
Other conditions Premature Labor	4 days

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE P. E. Sweet M.D.

Address Cumberland Md M. D. or other Date signed Aug 31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (bi-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 07615 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND? MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town GRANTSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. [redacted] MD.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME [redacted] EDWARD McCarthy Ferrell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife REICHARD? MARY J.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 24, 1871

8. AGE:	Years	Months	Days	If less than one day
	74	11	13	..... hrs. ..... min.

9. Birthplace KENTUCKY
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

FATHER 12. Name FERRELL, Unknown

13. Birthplace KENTUCKY

MOTHER 14. Maiden name Not known

15. Birthplace

16. Informant Thomas R Ferrell

Address Grantsville, Md

17. Burial, cremation, or removal. Which? Burial Date thereof Aug 9 1946 (month) (day) (year)

Cemetery or crematory Grantsville Cem

Location Grantsville, Md

18. Funeral director Wm Winterberg

Address Grantsville Md

19. Aug. 8 1946 (Date rec'd by registrar) Joseph B. Conklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7- 1946, at 930 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-17- 1946 to 8-7- 1946 and that I last saw h... alive on ..... 19.....

Immediate cause of death Chronic nephritis c uremia — DURATION .....

Due to ..... DURATION .....

Due to ..... DURATION .....

Other conditions arteriosclerosis Benign hypertrophy prostate
(Include pregnancy within 3 months of death)

Major findings of operations cystostomy Date of op. 7-31-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Howard L Tolson MD M. D. or other

Address Cumberland Md Date signed 8-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B1-a)

CERTIFICATE OF DEATH

★ 07616 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
519. Furnace St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 519. Furnace St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Benjiman Holliday Flake

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3 1872

8. AGE: Years	Months	Days	If less than one day
74	4	18	hrs. min.

9. Birthplace: Flintstone, Allegany Co. Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: John T. Flake
13. Birthplace: Flintstone, Md.

MOTHER
14. Maiden name: Margaret North
15. Birthplace: Flintstone, Md.

16. Informant: Charles W. Flake
Address: 519. Furnace St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/46 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Aug. 22, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21, 1946, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on August 20 1946

Immediate cause of death	DURATION
Uremia, Hypertension	2 weeks years
Due to: Hypertension C.V. Renal disease	years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. Waterbury M.D. M. D. or other
Address: 41 Greene St Cumberland Md. Date signed: Aug 24 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Outside City

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

* 07617 Reg. Diat. No. 4

1. PLACE OF DEATH:
County: ALLegany
City or town: SeIbert ~~Md.~~
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos.
Hospital, Institution, or street address where death occurred:
B & O Rg.
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 967 Shepard St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mrs. Emma Flora EMMA W. FLORA

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James W Flora
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 1864

8. AGE:

Years	Months	Days	If less than one day
81	10	—	...hrs. ...min.

9. Birthplace: Baberville Ind
(Town, county, and state)
10. Usual occupation: Government Clerk
11. Industry or business: (Retired) Postal Dept

FATHER
12. Name: Philipman Seaman
13. Birthplace: Ind

MOTHER
14. Maiden name: Margaret Woods
15. Birthplace: Ind.

16. Informant: Mrs S E Grant
Address: Washington D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 46 (month) (day) (year)
Cemetery or crematory: Rose Hill & Elm.
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. Aug. 31 19 46 (Date rec'd by registrar) J C Franklin Registrar
M. Dorsey

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 46 at about 7.50A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceeeed from ... 19... to ... 19...
and that I last saw her alive on Dead Aug. 29 19 46

Immediate cause of death: Fractured skull & neck — DURATION: At once
Due to: being (presume) hit by a B.&.O R.Ry engine
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8.29.46
Where did injury occur? Seibert (City or town) Allegany (County) Md. (State)
Injured at home, farm, industry, public place (where?) B & O railroad
Means of injury: Struck by engine Injured at work?

23. SIGNATURE: H.V.Deming H. V. Deming M.D. M. D. or other
Address: 175 Bedford St. Date signed: 8-29-46

County Medical Examiner - Allegany Co.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

DR. C.L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-e)

CERTIFICATE OF DEATH

★ 07618 Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 9 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town KEYSER
(If outside city or town limits, write RURAL and give nearest town)

Street No. RD # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
BABY GIRL GALL (Carol Kay)

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 19, 1946

8. AGE:

Years	Months	Days	If less than one day
0	0	14	..... hrs. ..... min.

9. Birthplace MARYLAND, Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name JAMES GALL
13. Birthplace MARYLAND, Cumberland

MOTHER
14. Maiden name CATHERINE JOHNSON
15. Birthplace MARYLAND, Cumberland

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4, 1946 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Maryland.

19. Aug 4 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 3 1946, at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2nd 1946, to Aug 2- 1946 and that I last saw her alive on Aug 2nd 1946

Immediate cause of death

Due to Congenital Endocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION
Emks

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other

Address Cumberland Med Date signed Aug 3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3-d)

CERTIFICATE OF DEATH

Dr. Diehl

07619

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 110 Wood Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Wood St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Catherine Geis

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward Geis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 23, 1869

8. AGE: Years: 77 | Months: 1 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Accident Garrett Cty. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Henry W. Kahl

13. Birthplace: Germany

MOTHER — 14. Maiden name: Louise Spoerlein

15. Birthplace: Unknown

16. Informant: Charles Geis

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30 1946 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md.

18. Funeral director: J. J. Hirst

Address: Frostburg, Md.

19. 8-29 1946 Mrs. Nancy M. Doe Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: August 28 1946, at 8:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946, to Aug. 28 1946

and that I last saw her alive on August 28 1946.

Immediate cause of death	DURATION
Chronic myocarditis	10 yrs.
Due to:	
Due to: Senility Arterio-Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M. D.

M. D. or other

Address: Frostburg, Md. Date signed 8/29/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 07620 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 526 Virginia Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No. 520 Virginia Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Leonard Franklin Glenn

3.(b) Social Security Number: 215-16-4570

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
m	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 1, 1903

8. AGE:

Years	Months	Days	If less than one day
43	6	1	..... hrs. ..... min.

9. Birthplace: Belle Vernon, Pa. (Town, county, and state)
10. Usual occupation: Crane operator
11. Industry or business: B & O R.R.
FATHER 12. Name: Joseph F. Glenn
13. Birthplace: Va.
MOTHER 14. Maiden name: Bertie Gordon
15. Birthplace: Cumberland, Md.
16. Informant: Raymond R. Tower
Address: 445 Maryland Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 5, 1946 (Month) (day) (year)
Cemetery or crematory: Rose Hill Cem
Location: Cumberland, Maryland
18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.
19. Aug. 5, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar acting

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2, 1946 at about 8.30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on Dead Aug 2 1946

Immediate cause of death	DURATION
Hepatic cirrhosis	?
Due to: Chronic alcholism	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other
Address: ..... Date signed .....
Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age of deceased is shown on FILM No. I 06 SEP 5 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 07621

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Bytimes Hospital
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Bx. P. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Molly Florence Jordon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James Jordan
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 23rd. 1878

8. AGE: Years	Months	Days	If less than one day
67	66	10	23 hrs. ..... min.

9. Birthplace: Frederick, Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business
FATHER 12. Name: Dennis Morgan
13. Birthplace: Ireland
MOTHER 14. Maiden name: Catherine Bender
15. Birthplace: Germany
16. Informant: Mrs. Laura Powell
Address: Mt. Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 19-1946 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage, Md.
18. Funeral director: Jacob Kaser
Address: Keating, Md.
19. 8-19 1946 Mrs. Nancy N. Pyle (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16 1946, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1946, to August 16 1946
and that I last saw her alive on August 16 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage.	2 days.
Due to: Vascular Hypertension & Arterio-Sclerosis.	
Due to:	
Other conditions: Chronic Nephritis.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William E. Mosley M.D.
M. D. or other
Address: Mt Savage Md. Date signed: 8-16-1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07622

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 86 Frost Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 86 Frost Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hampton Paul Griffith

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna Martha Griffith

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 27, 1856

8. AGE:

Years	Months	Days	If less than one day
90	2	13	..... hrs. ..... min.

9. Birthplace: Frostburg Allegany Md.

(Town, county, and state)

10. Usual occupation: retired contractor

11. Industry or business

FATHER

12. Name: Alexander Griffith

13. Birthplace: Maryland

MOTHER

14. Maiden name: Lydia Blocher

15. Birthplace: Pennsylvania

16. Informant: Mary Griffith

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12 1946 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: J. R. Hirst

Address: Frostburg Md

19. 8-12 1946 (Date rec'd by registrar) Mrs. Nancy H. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1946, at 7 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1946, to Aug 10 1946

and that I last saw him alive on Aug 9 1946

Immediate cause of death	DURATION
Uremia Sclerosis	many years
Due to:	
Senility	
Due to:	
Other conditions: Pneumonia R L Leg	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm Lane Jr MD M. D. or other

Address: Frostburg Md. Date signed 8-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

CERTIFICATE OF DEATH

07628

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 Independent St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret L. Hagelin

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife August Hagelin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24 1919

8. AGE: Years 27 Months 1 Days 15 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Lewis Lee

13. Birthplace Md. Pa

MOTHER 14. Maiden name Margaret Price

15. Birthplace Md.

16. Informant Mrs Mildred Lynch

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 12 46 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug. 12 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1946, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1946 to Aug 9 1946 and that I last saw her alive on Aug 9 1946

Immediate cause of death	DURATION
Acute valvular heart disease	
(Mitral stenosis) with	7
Due to Acute pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Vandemark M. D. or other

Address 110 S. Centre St. Date signed 10 Aug 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits ✓ Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

07624

CERTIFICATE OF DEATH

FILM No. I 06 SEP 5 1946

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Years

Hospital, institution, or street address where death occurred:
51 Browning St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 51 Browning St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1.

3.(a) FULL NAME: DENTON GRAVES HANSROTH

3.(b) Social Security Number: 705-07-9550

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lee(Harness) Hansroth

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): November 22, 1892

8. AGE: Years	Months	Days	If less than one day
63 53-	9	0	hrs. min.

9. Birthplace: Orleans Cross Roads, W. Va.
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: Baltimore & Ohio Railroad

FATHER
12. Name: John W. Hansroth
13. Birthplace: Orleans Cross Roads, W. Va.

MOTHER
14. Maiden name: Alice V. Roberts
15. Birthplace: Charles Town, W. Va.

16. Informant: Mrs. D. G. Hansroth

Address: 51 Browning St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/25/46 (month) (day) (year)

Cemetery or crematory: Petersburg Cemetery

Location: Petersburg, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 24 1946 (Date rec'd by registrar) Joseph A. Bartlett M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/22/46 19... at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/15/46 19... to 8/22/46 19...

and that I last saw h... alive on 8/22/46 19...

Immediate cause of death	DURATION
Myocardial failure	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: D. G. Williams M.D. M/D. or other

Address: Medical Bldg. Date signed: 8/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07625

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs

Hospital, institution, or street address where death occurred: 180 Railroad St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 180 Railroad St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ellen Harris.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John C. Harris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 1, 1871

8. AGE: Years	Months	Days	If less than one day
74	8	22	hrs. min.

9. Birthplace: Frostburg Allegany Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Yates

13. Birthplace: Wales

MOTHER — 14. Maiden name: Mary Price

15. Birthplace: Wales

16. Informant: Mrs. Stanley Morgan

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25 1946 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg

18. Funeral director: Jonas J. Durst

Address: 26 Union St.

19. 8-24 1946 Mrs. Nancy N. Poe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1946 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1946, to Aug 22 1946

and that I last saw her alive on Aug 9 1946

Immediate cause of death	DURATION
Hypertension	several years
Due to: Coronary Thrombosis	sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: W. O. McKinney Jr. M.D.

M. D. or other

Address: Frostburg Md Date signed: Aug 23 1946

Within corporate limits

Dr. Hodges

Carl Hafer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1918

07626

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #2 Baltimore Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Evangeline

Mrs. Cleo House

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ervan House

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): November 9, 1897

8. AGE: Years	Months	Days	If less than one day
48	9	13	..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER

12. Name: Denis Wilson

13. Birthplace: Maryland

MOTHER

14. Maiden name: Olive Middleton

15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 24 1946 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Methodist

Location: Near Cumberland, Md.

18. Funeral director: John J. Yodes

Address: Cumberland, Md.

19. Aug 24 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22 19 46 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 16 19 46 to Aug. 22 19 46

and that I last saw h alive on Aug. 22 19

	DURATION
Immediate cause of death: Peritonitis	6 days
Due to: Following Vaginal hysterectomy.	
Due to: Chronic myocarditis ?	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Stump relapse of uterus Date of op. Aug 9 46

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: W. P. Hodges, M.D.

Address: Cumberland, Md. M. D. or other

Date signed: 8/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 07627

1. PLACE OF DEATH:
County Allegany
City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Frank H. Kallaugh. | **3.(b) Social Security Number** None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife Bessie Dowden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 21 1860

8. AGE: Years	Months	Days	If less than one day
86	1	15	...hrs. ...min.

9. Birthplace Westernport Md.
(Town, county, and state)
10. Usual occupation Conductor Ry.
11. Industry or business Retired
FATHER 12. Name John Dewitt Kallaugh
13. Birthplace Md.
MOTHER 14. Maiden name Mary Simmon
15. Birthplace Md.
16. Informant Mrs. Clyde Wilson
Address Cumberland.
17. Burial Date thereof Aug 8 '46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. Aug. 8, 1946. J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1946 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to August 6 1946
and that I last saw h... alive on August 6 1946.

Immediate cause of death	DURATION
General Arteriosclerosis	5 years
Due to	
Due to	
Other conditions Gangrene R. foot.	3 Weeks.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. Brown M.D.
M. D. or other
Address Cumberland, Md. Date signed 8-7-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

DR. CL. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 07628 Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANCY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 BEDFORD ST. CITY
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME KELLEY, LORETTA MRS.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife KELLEY, ALLEN E. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 11, 1919

8. AGE: Years	Months	Days	If less than one day
27	5	23	hrs. min.

9. Birthplace MD. (Town, county, and state)
10. Usual occupation HWFE
11. Industry or business Own home
12. FATHER Name STEYER, GEORGE
13. FATHER Birthplace MD.
14. MOTHER Maiden name LIPSCOMB, SUSAN
15. MOTHER Birthplace MD.
16. Informant Memorial Hospital
Address Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6, 1946 (month) (day) (year)
Cemetery or crematory Red House Cemetery
Location Red House, Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Maryland
19. Aug. 5 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4th 1946 at 4.07 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 26 1946, to Aug 4th 1946
and that I last saw h.. alive on Aug 4th 1946

Immediate cause of death	DURATION
Acute Bacterial Endocarditis	10 days
Due to: Virus Infection Lung?	10 days
Other conditions: Chronic Endocarditis	several years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Diagnosis Confirmed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. L. Owens M.D. M. D. or other
Address Cumberland Md. Date signed Aug 4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

Within corporate limits: Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

07629

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs.

Hospital, institution, or street address where death occurred: Allegany Infirmary

How long in Hospital or Institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 Bedford St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Frank Keyser

3. (b) Social Security Number: 216-18-1072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Anna E Pyle

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 9 1872

8. AGE:

Years	Months	Days	If less than one day
74	6	28	____ hrs. ____ min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Merchant (Retired)

11. Industry or business: Clothing

FATHER

12. Name: Charles R Keyser

13. Birthplace: Md.

MOTHER

14. Maiden name: Elizabeth Wolfe

15. Birthplace: Md.

16. Informant: Chas R. Keyser

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Sons

Address: Cumberland

19. Aug. 9, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7, 1946, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 1946 to Aug 7, 1946 and that I last saw h[illegible] on Aug 6, 1946

Immediate cause of death	DURATION
Coronal	?
Due to: Hemorrhage	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. other

Address: Cumberland Date signed: 8-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (116)

CERTIFICATE OF DEATH

07630 4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 wk.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 830 Shriver Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earl Raymond Koegel

3.(b) Social Security Number 214-05-5960

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Mary Rawlings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4 1889

8. AGE:

Years	Months	Days	If less than one day
57	5	14	..... hrs. ..... min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business Furniture

MOTHER / FATHER

12. Name John Koegel

13. Birthplace Md.

14. Maiden name Katherine Zinke

15. Birthplace Md

16. Informant Mary Rawlings Koegel

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21 '46 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug 21, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Aug 18 1946

and that I last saw h... alive on Aug 18 1946

Immediate cause of death Arteriosclerosis.

Due to Esophageal diverticulum

Due to

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations Esophageal Diverticulum

Date of op. 8/12/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D.

M. D. or other

Address Cumberland Date signed 8/19/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

07631

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred

140 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and giva nearest town)

Street No. 140 Fredrick

(If rural, give LOCATION)

2.(c) If veleran, name war

3.(a) FULL NAME Jasper Newton Lang

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Florence Squires

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 1 1869

8. AGE:

Years	Months	Days	If less than one day
76	9	14	..... hrs. ..... min.

9. Birthplace Bridgeport W. Va.

(Town, county, and state)

10. Usual occupation R.R. Engineer

11. Industry or business Retired

FATHER 12. Name George W. Lang

13. Birthplace W. Va.

MOTHER 14. Maiden name Susan Smith

15. Birthplace W. Va.

16. Informant Donald J Lang

Address Grenbrg W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18 46 (month) (day) (year)

Cemetery or crematory N. of P Cem.

Location New Burg W. Va.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Aug 16 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Acting

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1946, at 12.30PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... im alive on Dead Aug. 15 1946

Immediate cause of death	DURATION
Coronary occlusion	immediate
Due to	
Due to	
Other condiltions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

M. D. or other

Address Date signed

Deputy Medical Examiner - Allegany Co.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07632

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 317 Reynolds St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 Reynolds St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sara Catherine Lesome

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John Lesome
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 30 1881
8. AGE: Years 64 | Months 8 | Days 2 | If less than one day ..... hrs. ..... min.
9. Birthplace: Bens Cove Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Andrew Jackson
13. Birthplace: Va.
MOTHER 14. Maiden name: Mary Innes
15. Birthplace: Pa.
16. Informant: Mrs Imyette Bowman
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6 1946 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Cumberland Maryland
18. Funeral director: Louis Stein & Co
Address: Cumberland Md
19. Aug. 5, 1946 (Date rec'd by registrar) J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2 1946 at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10/46 19.. to 8/2/46 19..
and that I last saw h.. alive on 8/1/46 19..

	DURATION
Immediate cause of death: Carcinoma of pancreas	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE John K. Lozyne M.D. M. D. or other
Address Cumberland Md Date signed 8/5/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07633

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred: 30 W. First St.

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 W. First St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Julius Alexander Linaburg

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice Hardy

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 18 1866

8. AGE: Years: 80 | Months: 2 | Days: 20 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Linaburg Md. (Town, county, and state)

10. Usual occupation: Engineer (Retired) R.R.

11. Industry or business

FATHER
12. Name: Frederick Linaburg
13. Birthplace: Md.

MOTHER
14. Maiden name: Rose Apple
15. Birthplace: Md.

16. Informant: Henry Linaburg
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 46 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug 11 19 46 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 19 46 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 46 to Aug 8 19 46 and that I last saw him alive on Aug 8 19 46

Immediate cause of death	DURATION
Myocardial failure	
Due to: Senility	
Due to: Arteriosclerosis	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [signature] Date signed: 8/9/46

Within corporate limits

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

*07634

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 29 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town ANTIOCH (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Virginia MRS. CLARA MARTIN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife GEORGE MARTIN

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) MAY 12, 1876.

8. AGE: Years	Months	Days	If less than one day
70	2	24	hrs. min.

9. Birthplace WEST VIRGINIA, Grant County (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name ROTRUCK, Abraham

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name [illegible] Moore

15. Birthplace WEST VIRGINIA

16. Informant George M. Martin

Address Antioch, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 8, 1946. (month) (day) (year)

Cemetery or crematory Rhuck's Cem

Location Antioch, W. Va.

18. Funeral director N. L. Rogers Funeral Director

Address Keyser, W. Va.

19. Aug. 8, 1946. (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 6, 1946 19.. at 8:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19.46 to Aug 6 19.46 and that I last saw her alive on Aug 6 19.46

Immediate cause of death	DURATION
Carcinoma of Lung	
Due to Carcinoma of breast	
Due to	
Other conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operation Suspected Carcinoma Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D.

Address Cumberland Date signed 8/9/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits Dr. Schindler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (743)

07635

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND? MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL, HOSPITAL

How long in hospital or institution? 12 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. AROUND CUMBERLAND? MD.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME McCRADY, RICHARD Mc CRADY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife ISABELLE, McCRADY

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 23 1874

8. AGE: Years	Months	Days	If less than one day
72	2	13	..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation UNEMPLOYED

11. Industry or business

FATHER
12. Name McCRADY, RICHARD
13. Birthplace MARYLAND

MOTHER
14. Maiden name CAMPBELL, ISBELLE
15. Birthplace MARYLAND

16. Informant Memorial Hospital
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 46 (month) (day) (year)

Cemetery or crematory St Patrick Cem

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Aug. 8, 1946. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1946 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on August 6 1946

Immediate cause of death	DURATION
Coronary Disease	2 days
Due to Hypertension	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Blanche M. Schindler M. D. or other

Address 41 Greene St Date signed August 7/946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07636

★ Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 18 Taylor St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 Taylor St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Margaret Loretta Mc Guire

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Peter Mc Guire

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): November 23 1872

8. AGE: Years 73 | Months 8 | Days 20 | If less than one day: hrs. min.

9. Birthplace: Barton Allegany Cty, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER 12. Name: James Logan

13. Birthplace: Maryland

MOTHER 14. Maiden name: Bridget Nolan

15. Birthplace: Maryland

16. Informant: Mrs. George Tippen

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16 1946 (month) (day) (year)

Cemetery or crematory: St. Michael's

Location: Frostburg Md

18. Funeral director: J. R. Dürst

Address: Frostburg Md

19. 8-15 1946 Mrs. Mabel M. Roe Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1946 at 11 02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1943 to 8/13 1946 and that I last saw h... alive on 8/13 1946

Immediate cause of death	DURATION
Acute Cholecystitis	24 hrs
Due to	
Due to	
Other conditions: Arteriosclerotic heart disease Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Faurlot Dey M.D. M. D. or other

Address: East Frostburg Date signed: 8/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 07637 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yrs 10 mos 13 days

Hospital, institution, or street address where death occurred:

Foundry Row

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No. Foundry Row

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Mc Ramee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Chas P. Mc Ramee

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 3 1869

8. AGE:

Years	Months	Days	If less than one day
76	10	13	...hrs. ...min.

9. Birthplace Mt Savage Md.
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business at Home

FATHER 12. Name Thomas Mallon

13. Birthplace Ireland

MOTHER 14. Maiden name Ellen Logsdon

15. Birthplace Ireland.

16. Informant Edward D. Mc Ramee

Address Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 1946 (month) (day) (year)

Cemetery or crematory St. Patrick Cem

Location Mt. Savage, Md

18. Funeral director Louis Stein Inc

Address Cumberland Md.

19. Aug 19 1946 (Date rec'd by registrar) Vernon McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1946, at 7A, M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 16 1946

and that I last saw h... alive on July 10 1946

	DURATION
Immediate cause of death Coronary Occlusion	2 hrs
Due to Hypertension Heart Disease	2nd yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Allan G. Kumler M.D.
M. D. or other

Address Cumberland Md. Date signed Aug 17 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

Dr P. E. Berry

07638

Reg. Dist. No. 6

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred: Riordan Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No. Riordan Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Ann Metz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank Metz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 22 July 1877

8. AGE:

Years	Months	Days	If less than one day
69	1	6	..... hrs. ..... min.

9. Birthplace: Lonaconing-Allegany-Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: own home

FATHER — 12. Name: Benjamin Lashbaugh

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary Greenhorn

MOTHER — 15. Birthplace: unknown

16. Informant: William Metz

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 31 August 1946 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: 111 Church St, Westernport, Md

19. Aug. 29 1946 (Date rec'd by registrar) P. E. Baughman M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 August 1946 19..... at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 19 46, to Aug 28 19 46

and that I last saw h.er alive on Aug 28 19 46

Immediate cause of death	DURATION
Chronic myocarditis	1 yr
Diabetes	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P E Berry M.D. (M. D. or other)

Address: Piedmont W. Va. Date signed 8/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (200-B)

CERTIFICATE OF DEATH

07639

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Shirley Ann Miller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 29, 1946

8. AGE: Years	Months	Days	If less than one day
0	1	17	..... hrs. ..... min.

9. Birthplace Cumberland, Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name William Miller
13. Birthplace Cumberland, Md

MOTHER
14. Maiden name Freda Bell
15. Birthplace Cumberland, Md

16. Informant William Miller

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 18, 1946 (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md.

18. Funeral director John F. Hoffman

Address Cumberland, Md.

19. Aug. 18, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1946, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 29, 1946, to Aug. 16, 1946 and that I last saw h[illegible] alive on Aug. 16, 1946

Immediate cause of death	DURATION
Unknown	
Due to Found Dead in Bed in Hospital - had been	
Due to treated for vomiting but was to go home any time -	
Other conditions X-Ray G.I. Tract normal -	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay K. Durrett M. D. or other

Address Cumberland Date signed Aug. 17, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1902

CERTIFICATE OF DEATH

07640

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett Co.
City or town: Crellin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Clarence Russell Moats

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 1, 1946

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
7 mos.	7	8		

9. Birthplace: Crellin, Garrett Co., Maryland (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Cecil T. Moats
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edna T. Lipscomb
15. Birthplace: West Virginia

16. Informant: Cecil T. Moats
Address: Crellin, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10, 1946 (month) (day) (year)
Cemetery or crematory: Moats Cemetery
Location: Near Crellin, Maryland

18. Funeral director: Emroy Boldin
Address: Oakland Md

19. Aug. 9 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1946 at 10:50P M

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from 7 August 1946 to 8 August 1946 and that I last saw h. alive on 8 August 1946

	DURATION
Immediate cause of death: BRONCHOPNEUMONIA	1 Day
Due to: SHOCK	2 Days
Due to: DEHYDRATION	3 WK
STARVATION	3 WK
Other conditions: GASTRO-ENTERITIS	3 WK.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Neville G. Weisman MD M. D. or other
Address: Cresaptown, Md Date signed: 9 Aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52-t)

CERTIFICATE OF DEATH

07641

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years

Hospital, institution, or street address where death occurred: 226. Cecelia St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 226. Cecelia St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clara R. Northcraft

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Alfred H. Northcraft

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 10, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	17	hrs. min.

9. Birthplace: Flintstone, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Rollins

13. Birthplace: Flintstone, Md.

MOTHER

14. Maiden name: Sarah E. Hanna

15. Birthplace: Flintstone, Md.

16. Informant: Alfred H. Northcraft

Address: 226. Cecelia St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/30/46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 30 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27, 1946, at 3-30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1946, to Aug 27 1946 and that I last saw her alive on Aug 25 1946

Immediate cause of death: Cancer of Bladder (urinary) — DURATION: 2 yr

Due to: [illegible] — 6 [illegible]

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos A. [illegible] M. D. or other

Address: Cumberland Md Date signed: 8/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07642 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
Miners hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Ivy Pearl Pope

3.(b) Social Security Number none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Henry Pope

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 26, 1896

8. AGE: Years: 50 Months: 2 Days: 23 If less than one day: ____ hrs. ____ min.

9. Birthplace: Eckhart, Allegany Cty., Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: John H. Eisentrout
13. Birthplace: Maryland

MOTHER
14. Maiden name: Malinda Crawford
15. Birthplace: Maryland

16. Informant: Wilson Pope
Address: Eckhart Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22 1946 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

18. Funeral director: J. P. Dudzik

Address: Frostburg Md

19. 8-21 1946 Mrs. Nancy M. Doe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1946 at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 1946, to Aug 19 1946 and that I last saw her alive on Aug 19 1946

Immediate cause of death: Carcinoma of Cervix

Due to: Ureteral

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

	DURATION
	2 yrs

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W M Lane Jr MD
M. D. or other

Address: Frostburg Md Date signed: 8-20-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

Dr Wolverton, Sr

07643

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 Years

Hospital, institution, or street address where death occurred:

34 Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 34 Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Carrie Caledonia Phillips

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter Phillips

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): 25 March 1890

8. AGE:

Years	Months	Days	If less than one day
56	5	4	...hrs. ...min.

9. Birthplace: Lonaconing-Allegany-Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Charles Cutter

FATHER 13. Birthplace: Lonaconing, Maryland

MOTHER 14. Maiden name: Christina Walker

MOTHER 15. Birthplace: Scotland

16. Informant: Walter Phillips

Address: 34 Main St, Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 Sept 1946 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: 111 Church St, Westernport, Md.

19. Aug. 31 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 August 1946, at 3:20p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8th 1946 to Aug 29 1946

and that I last saw her alive on Aug 29 1946

Immediate cause of death: Congestive Heart Failure, — Duration: 4dys

Due to: Myocardial Degen, — 1yr

Due to: — 2yrs

Other conditions: Diabetese Millitis,

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James H. Wolverton Jr M.D. M. D. or other

Address: Bedford Ave — Date signed: 8/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Outside of City limits

Dr. E. B. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

07644

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Spring Gap

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

Spring Gap, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Spring Gap.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Matilda Piper

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Lionel M. Piper

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) July 27, 1877

8. AGE: Years	Months	Days	If less than one day
69	0	25	..... hrs. ..... min.

9. Birthplace Dans Run Mineral, W. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER

12. Name Francis M. Moreland

13. Birthplace Levels, W. Va.

MOTHER

14. Maiden name Elizabeth Ulum

15. Birthplace Unknown

16. Informant L. M. Piper

Address Spring Gap, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 25, 1946 (month) (day) (year)

Cemetery or crematory Davis Memorial Cemetery

Location Oldtown Road Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Aug. 24, 1946 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946 at 6:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1946 to Aug 22 1946 and that I last saw h... alive on Aug 22 1946

Immediate cause of death	DURATION
Carcinoma of Uterus	about 1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Owens M.D.

M. D. or other

Address 133 Va Ave Date signed 8/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07645

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 Years

Hospital, institution, or street address where death occurred:
Sylvan Retreat

How long in hospital or institution? 8 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 101. Springdale St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bessie Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George Price

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 2 1879

8. AGE: Years	Months	Days	If less than one day
66	26	6	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: "

FATHER
12. Name: Hiram A. Wishmeyer
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Caroline Duncka
15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Harry L. Smith

Address: 814. Stewart Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/9/46 (month) (day) (year)

Cemetery or crematory: St. Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 9 (Date rec'd by registrar) 1946 J. L. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1946, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-30- 1945 to 8-7-1946

and that I last saw h.. alive on 8-7-1946

	DURATION
Immediate cause of death: Coronary Thrombosis Myocardial Degeneration	
Due to: Generalized Arteriosclerosis.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 8-8-46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

07646

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 years

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 144 N. Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Elizabeth Schilling

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Jack Schilling

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 9, 1886

8. AGE:

Years	Months	Days	If less than one day
60	1	22	____ hrs. ____ min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Sylvan Retreat

FATHER

12. Name: John S. Simon

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Elizabeth Meyers

15. Birthplace: Pennsylvania

16. Informant: Robert W. Smith

Address: Sylvan Retreat, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Aug. 31, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31, 1946, at 10:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24, 1946, to Aug. 31, 1946, and that I last saw h...er alive on Aug. 31, 1946.

	DURATION
Immediate cause of death: Acute dilatation	unkn.
Due to: Hypertension & C.V.S. Renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: B. M. Schneider M. D. Other

Address: 41 Grenet Date signed: Aug. 31, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07647

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 Years, 4 Months, 9 Days

Hospital, institution, or street address where death occurred:

23. Fifth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 23. Fifth Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lee Blackiston See

3.(b) Social Security Number: 705-07-9950

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanche E. See

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): April 22 1898

8. AGE: Years	Months	Days	If less than one day
48	4	9	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co. Maryland (Town, county, and state)

10. Usual occupation: Yard Master

11. Industry or business: Baltimore & Ohio Railroad

FATHER

12. Name: Amos E. See

13. Birthplace: Peru, W. Va.

MOTHER

14. Maiden name: Bessie Keller

15. Birthplace: Cumberland, Md.

16. Informant: Charles M. See

Address: 509. Maryland Ave, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 31, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1946, at 6-40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1946, to Aug 31 1946 and that I last saw h alive on Aug 31 1946

Immediate cause of death: Coronary Occlusion — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. S. Owens M.D. M. D. or other

Address: 133 Va Ave Date signed: 9/3/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits

Evidence for change of name shown on Film G108 11/29/46 dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07648

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 878 Shriver Ave,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 878 Shriver ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Anna Mae Simpson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20 1880

8. AGE: Years	Months	Days	If less than one day
66	5	19	hrs. min.

9. Birthplace: Mineral Co. W.Va. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: James Simpson

FATHER 13. Birthplace: md

MOTHER 14. Maiden name: Naomie Warwick

MOTHER 15. Birthplace: Md

16. Informant: Harry Simpson

Address: Cumberland md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17 '46 (month) (day) (year)

Cemetery or crematory: Philos Cem

Location: Westernport, Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland md

19. Aug. 12 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1946, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/15/46 1946, to 8/9/46 1946, and that I last saw h[illegible] alive on 8/9/46 1946.

Immediate cause of death	DURATION
Myocarditis Chronic	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. P. Franklin, M.D. M. D. or other

Address: Med. Bldg. Date signed 8/10/46

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07649

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 June 1946
Hospital, Institution, or street address where death occurred: Allegany Co. Infirmary
How long in hospital or institution? 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie Spurling

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Spurling
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1872 Unknown

8. AGE: Years: 74 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name
13. Birthplace: Unknown

MOTHER — 14. Maiden name
15. Birthplace: Unknown

16. Informant: Allegany County Infirmary
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 24, 1946 (month) (day) (year)
Cemetery or crematory: Rhodes Cemetery
Location: Westernport, Md

18. Funeral director: Ellsworth & Boal
Address: 111 Church St. Westernport Md

19. Aug 23, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 August, 1946 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1946, to Aug. 22 1946, and that I last saw h... alive on Aug. 20 1946

Immediate cause of death: Chronic Myocardial Degeneration

Due to: Generalized Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed: 8-22-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits DR Observe

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-M)

CERTIFICATE OF DEATH

07650

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND W. VA. County MORGAN

City or town PAW PAW (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME BABY BOY STEVENS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 10, 1946

8. AGE: Years	Months	Days	If less than one day
NEWBORN		1	hrs. min.

9. Birthplace MARYLAND Cumberland, Alleg Co. (Town, County, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace

MOTHER 14. Maiden name JULIA STEVENS

MOTHER 15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug. 12, 1946 (month) (day) (year)

Cemetery or crematory HOSPITAL

Location

18. Funeral director Same as above

Address

19. Aug. 12 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 11, 1946 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG. 10, 1946 to AUG. 11, 1946 and that I last saw him alive on AUG. 11, 1946

Immediate cause of death	DURATION
Depression R. Cranium	
caused by Fracture of Skull	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. E. Jones M.D. M. D. or other

Address Medical Bldg Date signed 8.12.46

Within corporate limits

Dr Canfield

07651

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Midlothian, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Alexander Stacy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora May Winebrenner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 12 - 1878

8. AGE: Years 67 | Months 10 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Midlothian Alleg. Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Coal Mines

FATHER — 12. Name: Alexander Stacy

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Hester Winebrenner

MOTHER — 15. Birthplace: Craft, Md

16. Informant: Mrs. Jessie Stacy

Address: Luntar, Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 - 12 - 1946 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Westernport, Md.

18. Funeral director: Jacob Walter

Address: Frostburg, Md.

19. Aug. 12, 1946. (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1946 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7, 46 to Aug 9, 46

and that I last saw him alive on Aug 7, 1946

Immediate cause of death	DURATION
Pneumonia	
Due to: Hemorrhage	
Due to: stomach	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Not explored.

Autopsy results: Carcinoma Date of Op. Pelvic Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. E. Canfield M. D. or other

Address: Cumberland Date signed 8/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. sign

Outside of City Limits

Dr. Koon

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-B)

CERTIFICATE OF DEATH

07652 4

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Allegany

City or town Spring Gap

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Spring Gap near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Oscar Wm Theodore Taschenberger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Frances Pittle

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	17	....hrs. ....min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Miller

11. Industry or business Flour & Feed Mill

FATHER 12. Name Carl Taschenberger

13. Birthplace Germany

MOTHER 14. Maiden name Augusta Kümmer

15. Birthplace Germany

16. Informant C. W. Taschenberger

Address 42 Marion St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2, 1946. (month) (day) (year)

Cemetery or crematory Mt Tabor

Location Spring Gap Methodist Ch

18. Funeral director J. L. Hitchins

Address Cumberland, Md.

19. Aug. 31, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1946 at 7:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1946 to Aug 30 1946

and that I last saw him alive on Aug 30 1946

Immediate cause of death	DURATION
Organic Heart Disease, Angina Pectoris	1 year
Due to Arteriosclerosis	
Due to Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos A Brown M. D. or other

Address Cumberland Md Date signed 4-3

Within corporate limits

DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07653

(159)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BABY BOY TASKER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 23, 1946

8. AGE: Years | Months | Days #2 | If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Md.
(City or town, county, and state) (STATE)

10. Usual occupation

11. Industry or business

FATHER 12. Name JAMES TASKER

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name LEOLA KELLER

15. Birthplace MARYLAND

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 26-1946 (month) (day) (year)

Cemetery or crematory Oakland

Location Oakland Md

18. Funeral director Emory Bolden

Address Oakland md

19. Aug. 26, 1946. J. L. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 25, 1946 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 25 1946, to Aug. 25 1946

and that I last saw h... J.M. alive on 19

Immediate cause of death	DURATION
Prematurity	
Due to Maternal toxemia	4 wks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W R Hodges, M.D. M. D. or other

Address Cumberland, Md. Date signed 8/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

R. W. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-F)

CERTIFICATE OF DEATH

07654

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

221 Virginia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 Virginia Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nora Belle Vanorsdale

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Mathias Vanorsdale

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 28, 1876

8. AGE: Years	Months	Days	If less than one day
70	6	7	..... hrs. ..... min.

9. Birthplace Morgan Co., W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name George Noland

13. Birthplace Hampshire Co, W. Va.

MOTHER 14. Maiden name Mary C. Zilar

15. Birthplace W. Va.

16. Informant Isaac Vanorsdale

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 8, 1946 (month) (day) (year)

Cemetery or crematory Barkley Springs Cemetery

Location Barkley Springs, W. Va.

18. Funeral director Chas. J. Duke

Address Cumberland, Md.

19. Aug. 5, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1946, at 12:12 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/1/46 1946 to 8/5/46 1946 and that I last saw her alive on 8/5/46 1946

Immediate cause of death	DURATION
(a) Toxemia	
Due to (b) Myocarditis	
Due to (c) Carcinoma of Liver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. W. Williams M. D. or other

Address ..... Date signed 8/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

Reg. Dist. No. 07655 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred:

Miners Hospital

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Midland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: M Paridice St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William Warnick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5, 1933

8. AGE: Years	Months	Days	If less than one day
13	2	15	hrs. min.

9. Birthplace: Midland, Allegany, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: Student

FATHER

12. Name: Hubert Warnick

13. Birthplace: Unknown

MOTHER

14. Maiden name: Annabelle McKinley

15. Birthplace: Scotland

16. Informant: Mrs. Wilson Ravenscroft

Address: Midland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23, 1946 (month) (day) (year)

Cemetery or Crematory: Oak Hill

Location: Lonaconing, Maryland

18. Funeral director: M. Eichhorn

Address: Lonaconing, Maryland

19. 8-22 46 (Date rec'd by registrar) Mrs. Hawley A. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20, 1946, at 2:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him dead 19..... to ..... 19.....

and that I last saw him alive on August 20th, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	immediately
Due to: 22 Calbert Bullet Wound entering face lodging in brain	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of: 8/20/46

Where did injury occur? Ocean Hill (City or town) Midland (County) Allegany (State) Md

Injured at home, farm, industry, public place (where)? On Mountain Ocean Hill above midland md

Means of injury: Injured at work?

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5a-a)

CERTIFICATE OF DEATH

07656

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
144 W. Main
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 144 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Wegman

3.(b) Social Security Number: none

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Chas. Wegman
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 25-1873
8. AGE: Years: 73 Months: 1 Days: 20 If less than one day: hrs. min.
9. Birthplace: Frostburg-alleg. md.
(Town, county, and state)
10. Usual occupation: house wife
11. Industry or business

FATHER
12. Name: Anthony Geplack
13. Birthplace: unknown

MOTHER
14. Maiden name: Henrietta Conpod
15. Birthplace: Frostburg md

16. Informant: Edith Stuffey
Address: Frostburg, md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) aug (day) 17 (year) 1946
Cemetery or crematory: allegany
Location: Frostburg, md.

18. Funeral director: J. F. Dyrst
Address: Frostburg, md

19. (Date rec'd by registrar) 8-15 1946 Mrs. Harvey A. Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 14 1946 at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1945, to Aug 14 1946 and that I last saw h.. ex.. alive on Aug 7 1946

Immediate cause of death	DURATION
Carcenoma of Right Kidney	7 Mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Wm Lane MD M. D. or other
Address: Frostburg Md Date signed: Aug 15 1946

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

CERTIFICATE OF DEATH

17657 Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 77 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 Bagnder
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret E. White

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: William E. White

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21 1869

8. AGE: Years 77 | Months — | Days 16 | If less than one day: hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home

FATHER 12. Name: William H. Watkins

13. Birthplace: Pa.

MOTHER 14. Maiden name: Adelaide Charles

15. Birthplace: Md.

16. Informant: Wm E. White

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10 '46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug. 10 1946 (Date rec'd by registrar) J. E. Franklin M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1946, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1946, to Aug 7 1946

and that I last saw h.... alive on Aug 7 1946

Immediate cause of death	DURATION
Uraemia	10 days
Due to: Glomerular Nephritis	2 years
Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Conlon M.D. M. D. or other

Address 41 Greene St Cumberland Date signed Aug 9 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Within corporate limits.

07658

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 515 Williams St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Agatha Will

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Augustine L. Will
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 5, 1878

8. AGE:	Years	Months	Days	If less than one day
	68	4	24	..... hrs. ..... min.

9. Birthplace: Pekin, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Hugh Ward
13. Birthplace: England

MOTHER
14. Maiden name: Winifred Maloney
15. Birthplace: Ireland

16. Informant: Augustine L. Will
Address: 515 William St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 2, 1946 (month) (day) (year)
Cemetery or crematory: St. Mary's Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Aug. 31, 1946 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1946, at 8:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945 to August 29 1946 and that I last saw h... alive on August 29 1946

Immediate cause of death	DURATION
mesenteric gastric hemorrhage, peritonitis	3 days
Due to: stomach ulcer	6 years
Due to:	
Other conditions: perforation	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: L. Bliss MD (M. D. or other)
Address: 69 Greene St Date signed: 8-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Within corporate limits

Hunter

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

07659

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifelong resident

Hospital, institution, or street address, where death occurred: 117 Fifth St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 117 Fifth St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Mary Cecelia Willard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Oscar Allen Willard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1861

8. AGE:

Years	Months	Days	If less than one day
84	8	0	hrs. min.

9. Birthplace: Cumberland Allegany Co Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Michael Meders

13. Birthplace: Cumberland, Md

MOTHER

14. Maiden name: Caroline ?

15. Birthplace: Unknown

16. Informant: Clara Wallace

Address: 213 Va Ave – Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28, 1946 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md

18. Funeral director: John J Hafer

Address: Cumberland Md

19. Aug 28, 1946 (Date rec'd by registrar) J P Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 25 1946, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1946, to Aug 25 1946, and that I last saw him alive on Aug 25 1946

Immediate cause of death	DURATION
Cardeo Renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T Barclay Hunter M.D. M. D. or other

Address: Cumberland Md Date signed: 8/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Please call 65
when this is signed.
Thank you!
Hafers

Within corporate limits

A. Jones

1454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07660

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years 29 Days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1 Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 328, Beall St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Winebrenner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 6 1940

8. AGE: Years	Months	Days	If less than one day
5	11	29	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: School

11. Industry or business: "

FATHER
12. Name: Charles Winebrenner
13. Birthplace: Cumberland, Md.

MOTHER
14. Maiden name: Anna Jane Imler
15. Birthplace: Bedford, Pa

16. Informant: Charles Winebrenner
Address: 328. Beall St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/46 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 7, 1946 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1946 at 6-10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 5 1946 and that I last saw her alive on Aug 5 1946

Immediate cause of death	DURATION
Acute Myocarditis	3 days
Due to Rheumatic fever	6 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other

Address: 110 S. Centre St. Date signed: Aug 6, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 17661 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred: 434 Chestnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 434 Chestnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war: I World War Navy

3. (a) FULL NAME: Samuel James Wood

3. (b) Social Security Number: 214-07-0797

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Willa Harrigan

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Sept. 13 1899

8. AGE:

Years	Months	Days	If less than one day
46	11	12	...hrs. ...min.

9. Birthplace: St Clair W. Va.
(Town, county, and state)

10. Usual occupation: Electrician Asst.

11. Industry or business: C. & S. Fire Co.

FATHER
12. Name: J Morgan Wood
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Margaret Kaden
15. Birthplace: W. Va.

16. Informant: Mrs Willa H. Wood
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 '46 (month) (day) (year)

Cemetery or crematory: St Peters & Pauls Cem

Location: Cumberland.

16. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19. Aug. 26 19 46 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 19 46, at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 19 46, to Aug 25 19 46 and that I last saw him alive on August 24 19 46

Immediate cause of death	DURATION
Acute myocardial failure	1 hr.
Due to: Auricular flutter	3 wks?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel James Wood M. D. or other

Address: 132 Lee St. Date signed: 8/26/46